DEVELOPMENT ASSOCIATES

Local Health Care and Governance

Reflections on Health Care Decentralization in Senegal

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Presented by
Birgitta Baade-Joret

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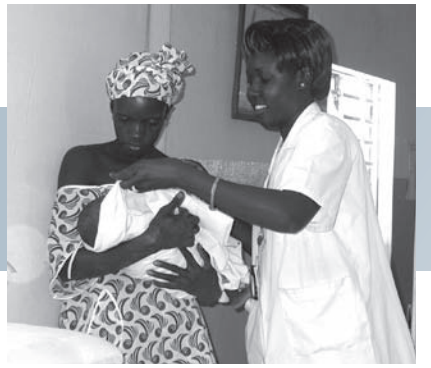
Reflections on Decentralizing Senegal's Health Care System

Introduction

Harnessing the potential gains of a decentralized health care system is no small task. Even in societies with a long history of democracy, stable leadership, and high levels of education, the concept can be difficult to grasp, let alone implement. Society must fully understand the benefits of a decentralized health care system before embracing change. This is especially challenging in societies living in mostly remote rural areas, which often have to cope with low adult literacy levels and limited numbers of secondary education graduates, chronically deficient infrastructure, insufficient human and financial resources, and rapidly unfolding political change.



Development Associates (DA) has become an important partner in USAID/Senegal's efforts to take on this challenge. The Decentralization and Community Health Initiative Project (DISC) began in mid-2000 with the objective to introduce, build up, and assist institutions in support of decentralized community health care planning and financing based on the principles of "good local governance" in USAID target areas. Meeting such a task requires the ability to turn complex concepts into comprehensive and applicable steps at all levels of civil society, while at the same time respecting the local legal and administrative framework.

I. Local control over health decisions

Successful decentralization reform begins with the transfer of responsibility for managing health funds to local governments. This devolution is meant to increase the equity of access and coverage and efficiency in the use of health sector resources, enhancing the quality of health service delivery and financial sustainability. Decentralization encourages increased local health financing through improved collection and allocation of fiscal income and mobilization of alternative revenue sources. In essence, giving stakeholders greater ownership encourages greater investment in the health delivery system's human and financial resources.

But how have ordinary Senegalese citizens and their elected local leaders handled these new governing powers? After all, it's been only 10 years since decentralization reforms were initiated. Do Senegalese citizens and their elected local leaders retain the necessary technical and managerial capacities, tools, and sufficient financial resources to effectively take control of their health decisions?

DISC has empowered 149 local communities, representing a third of the population, to identify and find solutions to their most pressing health care needs.

Early on, DISC set out to answer these questions and compile an inventory of challenges and opportunities. Analysts found that the decades-long practices of centrally allocated health budgets to the health district[1] level, based on a top-down approach to budgeting and planning, have left civil society and elected leaders with exceedingly little insight, experience and expertise in the management and operation of local health services. The introduction of cost recovery approaches based on the Bamako Initiative in the late 1980s had helped create some limited understanding of the financial implications of providing health care on the peripheries of society, but perceptions of the real costs of health care remained elusive.

1 A health district is defined as an administrative and technical structure that groups together a set of satellite health huts and health posts around a health center to provide health services to a defined geographical area of roughly 100,000-150,000 citizens (WHO).

About DISC

USAID/Senegal's current eight-year strategy (1998-2006) supports integrated and decentralized health service delivery in the country. This strategic approach seeks to strengthen the quality and sustainability of activities at the peripheral level, where the majority of Senegalese seek health care services. Following the close of a two-year pilot project, Development Associates was awarded its first DISC contract in mid-2000 to provide technical support within targeted health districts to encourage local level financing and build local level planning, implementing and monitoring capacities, with the goal of increasing ownership and sustainability of health services. After making considerable progress toward this goal, DA entered into a three-year DISC II contract with USAID/Senegal in August 2003 to expand the geographic coverage and scope of activities.

Headed by a physician with extensive experience in primary health care and decentralization projects in Africa and Asia, the DISC team operates with 20 staff members in a central office in Dakar along with 13 additional staff members located in eight field offices—a key component to the projects' intimate working relationship with district and local community counterparts. The efforts of core staff are supplemented by a cadre of short-term consultants providing additional expertise across the project's technical areas. Over six years of implementation, and with a total budget of $15.8 million, the DISC project has operated in 149 local communities in 22 health districts.

The lack of transparency in financial transactions raised suspicions at the local level concerning the way health structures were being managed. Compounding the problem, elected officials and community leaders were inexperienced in participatory community-based planning, budgeting, and financing of health activities. Even when such skills were present the appropriate tools to carry them out were absent. Groups promoting health outreach activities worked in isolation and had few opportunities to measure the benefits, efficiency, or quality of their efforts.

USAID has played an important role in opening up opportunities for change. Having established credibility with officials from Senegal's Ministry of Health (MOH) and civil society, USAID was ideally placed to support the initiation of legal and administrative reforms in 1996 that encouraged decentralization. The partnerships USAID developed with cooperating agencies also illustrated the possibilities for collaboration in a number of vital health areas[2] which were complemented by parallel USAID activities promoting democracy and local governance.

When DISC began operations in 2000, it first brought together stakeholders of community level health care to create appropriate consultative structures. Stakeholders were informed of the key implications of decentralized health management. The gathering initiated a productive dialogue between health technicians, locally elected officials and representatives of civil society, and focused on three key efforts summarized in the box on the next page, "DISC's Core Efforts." All three efforts, which are described in greater detail further on, have required the development of innovative tools that can be used in a participatory fashion at the community, district and regional levels.

Matching funds serve as an incentive to increase the collection of local taxes, allocate centrally provided funds and, above all, mobilize alternative local resources, such as funds from health committees or women's associations for priority health needs. Locally mobilized resources have therefore become a significant source of funding[3] for community health plans, encouraging tangible improvements to and investments in the health services and structures of local communities. This meaningful hands-on learning experience produces results with a clear and visible impact on the communities' health service delivery and contributes significantly toward a transfer of competencies to elected local leaders and supporting civil society.

Each locally developed plan corresponds to a building block for the subsequent development of district health plans. As a result, DISC has empowered local communities to reverse the typical chain of command for health planning and management by institutionalizing a bottom-up approach.

The introduction of contractual services has played an essential part in building up local organizational and management capacities in promoting health activities. While still in the experimental stage, this tool allows local communities to gain insight and control on the most basic and peripheral health services as a result of greater coordination, increased efficiency and the initial steps

2 The four technical domains are child survival (including malaria); maternal health and family planning; HIV/AIDS and sexually transmitted infections; and health financing.

3 Between 2001 and 2005, 149 partner communities raised about $1.5 million from mostly alternative resources to meet priority health needs. Matching the communities along with centrally allocated funds generated a total of $5.75 million to implement community-planned health activities perceived to be a priority.

toward a payment-for-services system based on actual performance.

Starting work in only a handful of communities, DISC incrementally increased the number of local communities participating and benefiting from the planning and matching grant exercise. By 2004, there were 149 participating communities in five regions. In all of these communities, DISC guided elected officials[4] and their councillors, health practitioners and representatives from civil society through the meticulous process of defining their health priorities, finding technically appropriate solutions, setting up a budget, identifying and mobilizing resources to finance the planned activities, reviewing the scope of activities on available finances, communicating and presenting the final operational plan and ultimately implementing and monitoring the planned activities. Working through the whole range of steps inherent to a complex planning exercise provides ordinary citizens with stepping stones toward becoming responsible actors and partners in participating in their community's health decisions.

However, embracing and exercising the privilege of new governing powers comes with the need for accountability in all decisions made and actions taken. The concepts of accountability and transparency must be addressed at all levels if decentralization is to succeed. The aim is to spread the principles of good governance among all partners in health management in order to improve the prevailing administrative culture. This all takes time, however.

Newly responsible constituents and their elected leaders are still adjusting to a new legal framework and the administrative procedures adopted in 1996 to decentralize health care and eight other essential domains.[5] A profound change in government that brought in a new administration in 2000 and dependence on transitory local government structures through 2002 raised some obvious challenges.

Nonetheless, 149 local communities, representing about 35 percent of the Senegalese population, have taken greater ownership of their local health decisions and are increasingly gaining insight into and control over health promoting activities. This has been made possible, in part, by the contracting of these activities to a newly created legal entity.

DISC's Core Efforts

To promote sustainable community control of health decisions, DISC bases its approach on three core innovative efforts:

- The interactive, community-based development and implementation of detailed operational plans relating to health care delivery.
- The conceptual, operational and institutional implementation of legally binding agreements between communities and their health promoting activities through the introduction of contractual services.
- Embedding good governance principles at all levels of conception, operation and implementation to promote positive change, stakeholder ownership and, ultimately, sustainability.

The relatively rapid adoption of community-based planning, budgeting and management of health funds and contractual services is a direct result of the sense of empowerment these changes have brought to communities, their locally elected leaders, health technicians and community interest groups.

Innovation needs a creative, flexible and open-minded environment to succeed. The strong leadership of DISC's technical team, the continuous and constructive collaboration with USAID's health office, the Ministry of Health and DA's home office has helped energize and sustain the project.

II. Encouraging local communities to raise funds to help shape their future

Decentralization can only be effective if the transfer of substantial public sector responsibilities to local governments is accompanied by devolution of management authority and resource allocation decision-making. In the case of Senegal's health decentralization efforts, this requires two essential conditions to be realized at the community level:

- Availability of sufficient financial resources.
- Adequate managerial capacity to administer these resources.

DISC's review of how these conditions are being addressed within the USAID target communities reveals

4 In urban communities this includes the majors and their municipal councillors; in rural communities it includes the president of the rural community and rural councillors.

5 The other decentralized domains include natural resource management, youth and sports, culture, education, planning, regional development and urbanism. The technical and managerial local capacities built in the context of health decentralization can be expanded on and maximised by responsibilities in the other sectors.

Local Empowerment

A striking example of DISC's impact on local empowerment took place in 2002 in one of the partner communities. During the POCL-planning process, the women's association pledged considerable funds toward the renovation of their maternity while the mayor assured a contribution of two million CFA from local tax revenue. Along with the matching funds, the total sum would have covered the bill for much needed renovations. The women's association swiftly mobilized their funds and deposited them in the special matching account administered by DISC. The mayor, however, did not respect his pledge in the agreed upon timeframe. Keeping to the approved protocol, DISC consequently did not liberate the matching funds, as all the funds promised for the specific activity had not been deposited and the renovation suffered considerable delay. When discontented members of the women's association demanded the mayor honor his commitment and threatened a public march on town hall, it didn't take long for the mayor to transfer the funds. Having met the conditions for disbursing the matching grants, the renovation proceeded as planned.

insufficient levels of resources to meet local health needs along with a lack of managerial competency and experience. In rural communities, public resources are mostly limited to the collection of a rural tax.[6] Recovery rates of this annual flat tax by the local treasury are generally low. The finances of municipalities are more diversified and substantial, with income from taxes on commerce, markets and any small industry. However, in both cases contributions from a centrally supplied decentralization fund[7] cannot fill significant funding gaps. Hence, there is little choice but to mobilize additional funding from alternative sources at the local level to meet health needs.

But how can local governments and communities be encouraged to raise health funds? DISC has responded to this challenge in steps:

- Inform the communities and train their elected officials about their new responsibilities in managing local health service delivery, as stipulated in the decentralization laws.
- Provide each community with participatory and transparent planning and budgeting tools.
- Foster an in depth-understanding and appropriation of these tools by assisting the application and use of these tools in detailed community planning exercises.
- Establish a list of perceived, objective and technically sound priority health actions.
- Identify the financial needs to realize these actions by establishing a realistic budget.
- Identify and mobilize the available resources to carry out the planned activities.

At this point in the planning process, local communities and their elected leaders have become more conscious of the fact that current local funds are insufficient. The choice they face is whether to cancel priority activities or raise additional funds. Being able to quantify the gap between needs and resources and prioritizing activities helps communities determine how much additional resources are needed. Frequently, DISC has seen a willingness among civil society groups, such as health committees, women's associations and water well committees, to mobilize their own resources provided that activities respond to a specific need and that funds are used efficiently and transparently.

DISC contributes matching funds as an incentive to mobilize both public and private resources at the local level. Increasing the total financial volume permits communities to achieve visible and effective improvements to their health services and structures. Visible improvements help justify and motivate future mobilization of resources.

Once agreed upon activities are identified and funding is earmarked, a comprehensive annual community health plan (POCL)[8] is established. These health plans are presented and negotiated at both the district[9] and regional level and constitute the building blocks of the respective district and regional health plan. The map on the next page demonstrates the expansive coverage of community health planning and matching fund activities within the USAID target areas. The increasingly interconnected nature of health needs of neighboring communities amplifies the impact of these activities. Coherent geographic coverage permits shared experiences at the

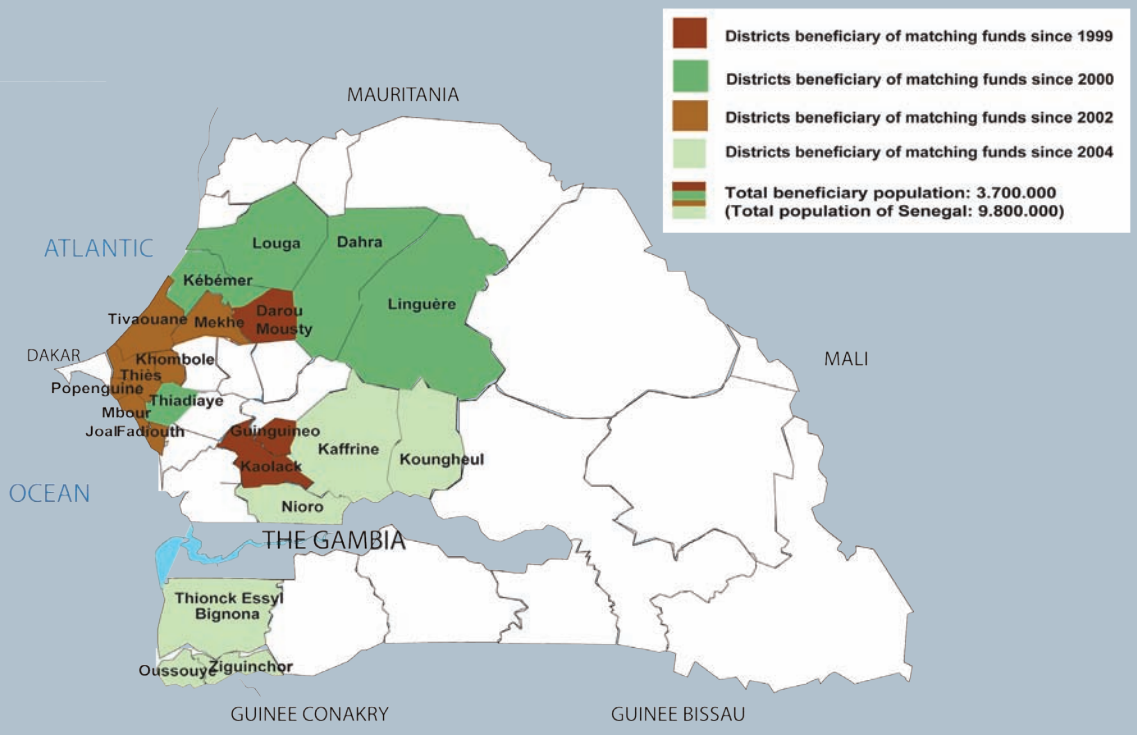
6 Rural tax is payable to the local treasury department by every inhabitant of a rural community aged between 14 and 70 years. The tax amounts to 500 or 1,000 CFA, equalling $1-2 per capita per year. About 10 percent of the total is allocated for health services.

7 In addition to the lack of capital, disbursement of centrally allocated health funds occurs with a significant delay as a result of bureaucratic procedures.

8 Plan Operationnel de Collectivité Local.

9 As a historic consequence of the World Health Organization's policy of promoting health districts as operational entities in efficient health service delivery, the health sector in Senegal still includes health districts. However, these districts are not officially considered administrative entities. Senegal's decentralization policy defines municipalities and rural communities as the most decentralized local units with governing powers.

Coverage of Matching Funds in Senegal



Source: DISC

local, district and regional level.

DISC established control systems to ensure the efficient and transparent use of the funds collected. Matching funds are disbursed only once the publicly pledged and alternative community funds are deposited in DISC administered accounts. Disbursement is always linked to the provision of a detailed plan and budget representing specific actions from the integrated community health plan (POCL). Careful measures are taken to assure that USAID matching grants are distributed equitably: smaller and poorer communities benefit from a comparatively higher ratio of matching their own funds.

Local leaders gain considerable credibility and advantage from an active participation and appropriation of the community planning and financing procedures. These benefits have a direct impact on the motivation of local leaders to sustain the DISC approach. After all, following the principles of accountability and transparency is also likely to pay off at the ballot box.

The DISC approach promotes and sustains the necessary transition from traditional leadership structures toward democratically elected leadership. Creativity, flexibility and exceptional skills in conception and management have been called for to assure the successful transfer of competence to growing networks of local communities. Provided that the tools for a participatory and transparent planning and budgeting process are adequate, local communities and their elected leaders illustrate the ability to rise to the occasion in taking on greater governing responsibilities that shape their future.

III. Developing Local Management Capacity to Deliver Contracted Community Services

Since the 1978 Alma Ata conference, the World Health Organization (WHO) has endorsed health promotion as the most fundamental of all health services. Health promotion was conceived of as an effective, cost-efficient and culturally appropriate approach to bridge the gap between communities and their health systems. The main objective is to empower people to make more informed decisions in a number of areas that affect their health. Health promotion goes beyond traditional health care strategies by promoting health-seeking and health-preserving behaviors.

Conceived and directed by an array of technical agencies, health promotion activities are typically carried out by

lay community members who receive basic training in the methods and contents of their specific topic. Technical competence is usually restricted to a narrow technical area and wages are limited to motivational or incentive payments to sustain the "voluntary" approach, as promulgated under WHO guidelines. More often than not, health promotion measures are vertical activities that, by and large, coordinate the agendas of financing donor agencies, the executive outfits and the responsible health services.

However, the recipient communities and their leaders are frequently deprived of any valuable input towards the technical content, organizational concerns or financial dealings of these outreach activities. This is an apparent contradiction to the operational role of local communities put forward within Senegalese health decentralization reform. Based on the principle of stakeholder involvement and ownership as the key to efficient use of health services at all levels, it's imperative to link the recipient community to the providers of outreach services. Efficient contractual links can only be established between two legally binding entities. The local community, represented by their elected leader, constitutes one partner. Yet, historically there has been no legal body to represent the other crucial partner, the health promotion agents.

Health promotion providers, as groups or loosely interconnected individuals, are often unstable, heterogeneous and unstructured. Due to frequently informal work agreements and unforeseeable employment opportunities, there is a general lack of continuity within these groups of already-trained individual agents. This contributes to inefficiencies in the use of both human and financial resources.

The need for greater cooperation and rationality in the delivery of resources for USAID-financed health outreach activities[10] within target areas and the demand for more realistic integrated health service delivery at the periphery fostered the move toward a more novel approach. Another factor in this shift was complying with an explicit MOH request "that interventions of executing agencies in favor of health should reinforce their partner services all the while disturbing them as little as possible." Extensive interagency consultations allowed DISC to conceptualize and implement two innovative tools:

- The organization of existing health promotion agents in non-profit associations (ARPV).[11]
- The introduction of service contracts between the community and the association representing their health promotion agents (ARPV).

Organizing the individual outreach agents of all partner communities within similar, legally valid associations, the ARPV[12]—based on the same set of coherent internal rules and regulations—creates the missing partner to establish a formal and efficient relationship to manage health outreach activities. The introduction of model service contracts between both beneficiaries and providers as partners of health promoting activities subsequently formalizes and institutionalizes this relationship.

The framework of non-profit associations offers multiple benefits both for the individual agents as well as the donor agencies and the beneficiary communities. The individual agents gain more stable perspectives of future professional opportunities and increase their bargaining power with financing agencies. Establishing an organizational culture within their association can lead to more innovative ways to set standards and to achieve better results. The ARPV present an entity that can market and offer numerous services to a number of financing agencies. These agencies can amplify technical and managerial-capacity-building investment by working with a more consistent and organized workforce and harmonizing approaches within the target population. Changing attitudes and behaviors is notoriously slow and difficult to achieve. The greatest impact to stabilize the environment can perhaps be made by increasing the coherence of approaches and content of messages.

Ultimately, the beneficiary communities gain the necessary insight in the technical content and the organizational and financial concerns of outreach activities. The service-contract, stipulating the content, approach and pay structure of outreach activities, is signed between the elected local official of the client-community and the president of the ARPV. Payment, even though still financed by external donor funds, is awarded after a review of performance and achievements. This is the first step toward linking payment to performance review. Setting up contractual health promotion services allows the community to become an active partner at the most basic level of health service delivery and contrasts its passive role in the previous

10 Again, USAID-financed health outreach activities encompass four technical domains: child survival (including malaria); maternal health and family planning; HIV/AIDS and sexually transmitted infections; and health financing.

11 Association des Relais PolyValents.

12 An ARPV consists typically of about 25 health promotion agents with varying fields of technical competence.

health care delivery system.

The ARPV approach offers opportunities for developing organizational and management capacities for both outreach providers and beneficiaries. By June 2004, DISC had assured the transfer of these competencies towards the constituents and health promotion agents of 110 local communities. A total of 123 ARPV were established, equipped with a binding statute and interior rules and regulations. They received training in good governance in addition to an integrated technical and managerial component on reproductive health. Subsequently a total of 123 service-contracts between the communities and the ARPV were drafted and signed, thus assuring widespread use of this novel approach. The contracts contain detailed plans of all outreach activities financed by USAID in coordination with cooperating agencies.[13]

DISC's creative funding mechanism encourages communities and elected leaders to form a consensus and follow through with spending commitments.

The integrated planning and monitoring of outreach activities reveals that the average cost for one year of comprehensive intervention in health promoting activities[14] falls just short of $4,000 per community. Knowing the attached price tag allows communities to appreciate the investment in health outreach and to include it in their future health plan and budget.

The ARPV have proven to be a valid partner for other donors and payers. Several ARPV signed contracts with the MOH and other donors to intervene in the recent cholera outbreak, for instance. Increasing their potential clients will further motivate the individual ARPV to enhance the quality of their services and strengthen management capacity.

Decentralized health planning at community-level along with the introduction of contractual services between clients and providers of outreach health services are DISC's main key innovative approaches. They allow civil society and their elected leaders to expand competence and built technical and managerial capacities in health service delivery. Tying stakeholders into the entire range and sequence of these actives allows local leadership to be involved at all levels. Above all, ordinary citizens organized in public interest groups become equally responsible and competent partners in their local health decisions.

IV. Transparency as a critical component for effective decentralization

In an increasingly democratic and pluralistic society, the ways results are achieved deserve as much attention as the results themselves. Adhering to the doctrine of good local governance in the management of decentralized health service delivery offers two key opportunities: 1) a concrete learning opportunity on how civil society and elected officials should interact and proceed at any level; and 2) a significant endowment of credibility. Both will promote long-term sustainability of the chosen approach.

In the best of circumstances, decentralization reform can build and expand on an inherent set of good-governance practices, encouraged by widespread participation of civil society within a stable democracy. These good local governance practices, as applied to health service decentralization, involve four main aspects:

- Efficient service delivery legitimacy.
- Transparency of management.
- Accountability of local authorities.
- Participation and direct implication of civil society in all levels of local health management.

However, an inventory of past and, for the most part, still prevailing governance practices in Senegal continues to pose a major challenge for DISC. Corruption is a serious problem, as indicated by Senegal's ranking as No. 76 out

13 As the responsible coordinating structure for the ARPV, DISC also dealt with a challenge inherent to the project approach in health development: to negotiate and pilot this novel approach in respect of contractual and organizational constraints between and within all cooperating agencies. Strong leadership and frequent and consensual interagency coordination helped keep the best interest of the target groups at the top of the agenda.

14 The activities implemented by the ARPVs include community presentations of selected health topics, community mobilization and targeted home health visits with individuals and families in the four technical health domains covered by USAID in the target area.

of 133 countries surveyed for Transparency International's 2003 corruption perception index.[15] A recent review of the health sector cites bad practices in health, including pilfering, corruption, parallel billing, murky procurement practices, and absenteeism of on duty staff.[16]

These disappointing practices are a result of complex underlying factors and experiences. Low and uninspiring salaries are in constant friction with high and often unpredictable personal and family financial needs. In this context, the combination of poorly managed resources and structures and opaque administrative procedures can present temptations that are hard to resist. More basically, the perceived lack of accountability and responsibility for public goods must give way to the concept of stakeholder ownership if the situation is to improve.

Participating communities have raised $1.5 million from mostly non-traditional sources, which are combined with matching funds to meet priority health needs.

The potentially hazardous combination of a lack of experience in good governance at the community level and the prospective allocation, management and disbursement of considerable financial resources by these same communities and their elected leaders has compelled DISC to scrutinize the underlying rules and regulations for all procedures. Accomplishing this has required outstanding managerial, accounting and communication skills. But most crucially, these conditions have provided the opportunity to implant the principles of good governance in all concepts, operations and actions to be developed and implemented, which gives communities practical experience and a standard for good practice.

How has transparency been achieved? First, DISC identified all local health care stakeholders, bringing together health care providers, elected local leaders and clients. Subsequently, these groups received intensive training on the legal and administrative framework of health decentralization. In many cases, participants reported that this was the first time their respective roles, privileges and obligations had been explained. In respect to legislation, the internal rules and regulations for all implicated civil and governing managerial structures were revived and made operational. New sets of references were used to identify the technical tasks and appropriate actions needed to establish and implement the community health plans. The approach was completed with the use of networks of management meetings with frequent feedback and multiple control loops, open to constant fine-tuning and amendments.

As a consequence, transparency at all levels became DISC's key goal over the life of the project. Full transparency allowed civil society groups to understand and trace the financial and human contributions to the established community health plans for their own districts as well as others. It also built up the level of trust needed by local communities to mobilize financial resources and place them in off-limit accounts accessible only with the signatures of the district medical officer, the elected community leader and a representative of DISC. Over the life of DISC, the 149 partner communities have raised and mobilized an astonishing $1.5 million from mostly alternative resources for their own health needs, thus far exceeding the expectations. Full transparency contributed to a more efficient and effective use of these scarce resources by preventing duplicate financing. Finally, it allowed communities to identify improvements and achievements of their health service delivery, providing the first fruits of community ownership.

Community ownership is the very key to successful health decentralization. By increasing stakeholders' willingness to mobilize additional human and financial resources for health and by assuring their most equitable and efficient use, decentralization will ultimately alleviate poverty and improve the lives of ordinary citizens—the essence of decentralization.

Flawed practices and irrational behavior at both the individual and community level are hard to overcome and slow to change. Within its 149 partner communities, DISC has made a positive contribution. In these partner communities, democracy at the grass-roots level has been strengthened by improved effectiveness, transparency and accountability of local health governments.

15 USAID/Senegal FY2004/05 Congressional Budget Justification.
16 A very detailed report on "Governance and Corruption in the Senegalese Health Sector" was published by Le Forum Civil, the Senegalese section of Transparency International in late 2004.

Birgitta Baade-Joret *is a public health physician with 20 years of experience in Africa focusing primarily on community and clinic based services, maternal and child health, and reproductive health.*

For Further Information on DISC

Bernardo B. Callaway Kleiner, MPH
Associate
Development Associates
2300 Wilson Boulevard, Suite 300
Arlington, Virginia 22201
703.276.0677
BKleiner@devassoc.com
www.devassoc.com

Vincent Joret, MD, MPH
Chief of Party
Project DISC
Rte. de la Pyrotechnie
BP 16659, Dakar-Fann.
Senegal
221.869.3600
vjoret@disc.sn

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